SECTION B: FORMS AND INSTRUCTIONS

REFERENCE #

- ❑ Screening Tool _____ RS FORM 1
- ❑ Medical Necessity Statement Form _____ RS FORM 2
- ❑ Treatment Plan
  Facility (Day Service Treatment Plan/ Report- 8 pages) _____ RS FORM 3A.1
- ❑ Amendment to the Treatment Plan
  Facility _____ RS FORM 3A.2
- ❑ Progress Summary Note
  Facility _____ RS FORM 4A
- ❑ Termination and Process for Appeals
  Notice of Termination form and Process for Appeal letter (2 pages) _____ RS FORM 6

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

Rehabilitation Supports Screening & Referral Form

INSTRUCTIONS: Complete all sections below. A referral to the Lead Clinical Staff (or Life Skills Specialist) should only be made if a "yes" response is made for all items under 3, 4 & 5 below.

Consumer's Full Name: _____ DOB: _____/_____/_____

Medicaid #: __ __ __ __ __ __ __ __ __ __ SSN: __ __ __- __ __-__ __ __ __

1) The consumer receives services through DDSN:

☐ Mental Retardation Division ☐ Autism Division ☐ Head & Spinal Cord Injury Division

☐ Other Specify (ex. High Risk Infant): _____

2) The consumer is:

☐ Currently in school

☐ Receiving Community Long Term Care (CLTC) Elderly and Disabled Waiver Services*

☐ Receiving HASCI Waiver Services*

☐ None of the above

* If receiving CLTC or HASCI Waiver Services explain why waiver services will not meet the person's needs:

_____

NOTE: If receiving CLTC Elderly and Disabled Waiver Services, notification to CLTC case manager must be made prior to receiving rehabilitation support services.

3) The consumer has expressed a need to develop, retain, or restore an optimal level of functioning in one or more of the following skills: Self-Care, Community Living Skills, Psycho-Social and/or Medication Management / Symptom Reduction:

☐ Yes ☐ No

4) The consumer would like to develop an enhanced capacity for personal independence essential for successful community living:

☐ Yes ☐ No

5) The consumer meets the following Rehabilitation Support eligibility requirements:

☐ Yes	☐ No	Meets DDSN eligibility criteria
☐ Yes	☐ No	Is a Medicaid recipient
☐ Yes	☐ No	Is not enrolled in the MR/RD Waiver
☐ Yes	☐ No	Does not reside in an Intermediate Care Facility for the Mentally Retarded or Nursing Home
☐ Yes	☐ No	Is approved to receive Rehabilitation Support Services by their Service Coordinator or Early Interventionist with authorization from the home board provider

_____ _____

Signature of Service Coordinator/Early Interventionist Date

_____ (_____) _____

Provider of Service Phone

LCS USE ONLY

SERVICE AWARDED: ☐ Yes ☐ No (explain: _____) ☐ Added to Waiting List

LCS Signature: _____ Date: _____

RS Form 1 (8/04)

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

Rehabilitation Supports

MEDICAL NECESSITY STATEMENT

Please Type or Print

Consumer's Name: _____

Date of Birth: _____

Social Security Number: _____

Medicaid #: _____

Medical Necessity Criteria for Rehabilitation Supports: The consumer is a Medicaid recipient and meets DDSN eligibility criteria, who needs to develop, retain or restore an optimal level of functioning in one or more of the following areas: Self-Care Skills; Community Living Skills; Psycho-Social Skills; and/or Medication Management / Symptom Reduction Skills; in order to enhance the consumer's capacity for personal independence essential for successful community living.

☐ Approve. I recommend that the above-named consumer be provided Rehabilitation Supports for the purposes of correcting or ameliorating physical or functional limitations and/or mental illnesses and/or other conditions which, if left untreated, would negatively impact the health and quality of life of the consumer. The consumer meets the medical necessity criteria for Rehabilitation Supports.

☐ Deny. I do not recommend that the above-named consumer be provided Rehabilitation Supports. The consumer does not meet the medical necessity criteria for Rehabilitation Supports.

_____ _____

Signature of Physician or Licensed Practitioner of the Healing Arts *Professional Title*

Please Type or Print

_____ _____

Name of Physician or Licensed Practitioner of the Healing Arts Date

_____

Address

SOUTH CAROLINA Department OF Disabilities AND Special Needs

FACILITY-BASED DAY SERVICE & TREATMENT PLAN / REPORT

INSTRUCTIONS FOR PLAN:

1. The plan should be used for all consumers who receive a day service (except supported employment).

2. The Day Director (or Lead Clinical Coordinator for Rehabilitation Supports) is responsible for ensuring that the plan is:

    - Complete, accurate and of quality.

    - Developed no later than twenty (20) business days after the consumer has been approved to receive a day service by their Service Coordinator or Early Interventionist with authorization from the home board provider; and annually (e.g., within 365 days) thereafter.

    - Easily accessible for direct support staff to reference, and the original should be maintained in the consumer's day record.

3. Provider agencies should use the DDSN Day Service & Treatment Plan form, or a form chosen by the provider and approved by DDSN. The instructions and form can also be accessed at: http://ext.ddsn.sc.gov

4. On the first page of the report (top right), place a mark to denote how the form is being used (e.g., Day Plan), and identify the date the plan was developed.

5. The DDSN Day Service & Treatment Plan must include the following information listed within Sections 1-7 below:

    NOTE: For consumers who receive Level I Service Coordination, and upon receipt of the approved Single Plan, if the Day Report for Single Plan Development and Single Plan coincide, the box indicating "Day Service & Treatment Plan" may be marked, dated and used as such to avoid having two separate documents (one marked as Day Report for Single Plan Development and one marked as Day Service & Treatment Plan).

INSTRUCTIONS FOR REPORT:

1. Completion of this report is required for consumer receiving Level I Service Coordination and a day service (except supported employment).

2. The Day Director (Lead Clinical Coordinator for Rehabilitation Supports) is responsible for ensuring that the report is:

   - Complete, accurate and of quality.
   - Submitted (via copy) to the consumer's service coordinator no later than fifteen (15) business days prior to the consumer's annual single plan review date, or as requested by the consumer's service coordinator.
   - Maintained (e.g., original) in the consumer's day service record.

3. Provider agencies should use the DDSN Day Report for Single Plan Development form, or a form chosen by the provider and approved by DDSN. The instructions and form can also be accessed at: http://ext.ddsn.sc.gov

4. On the first page of the report form (top right), place a check to denote how the form is being used (e.g., Report for Single Plan Development), and identify the date the report was developed.

5. The DDSN Adult Day Report for Single Plan Development must include the following information listed within Sections 1-6 below:

   NOTE: For consumers who receive Level I Service Coordination, and upon receipt of the approved Single Plan, if the Day Report for Single Plan Development and Single Plan coincide, the box indicating "Day Service & Treatment Plan" may be marked, dated and used as such to avoid having two separate documents (one marked as Day Report for Single Plan Development and one marked as Day Service & Treatment Plan).

SECTION 1: General Information

A. The type of day service the consumer is authorized by the service coordinator to receive (e.g., day habilitation, prevocational, or rehabilitation supports).

B. The source authorized to fund the service (ex. MR/RD Waiver; Medicaid State Plan; Other (Specify).

SECTION 2: Identifying Information

A. The consumer's full name. For example, Robert Allen Zimmerman.

B. Consumer's date of birth.

C. Home telephone number and address (when applicable, name of facility) of where the consumer resides.

D. Name and relationship of the consumer's primary contact (to include telephone number and address).

SECTION 3: Critical & Emergency Information

A. When applicable, identify quick reference information critical to the consumer's health, behavior, and/or safety that is essential for staff to be aware of in order to prevent potential harm to the consumer or others. For example, allergic to pecans, 1:1 supervision while bathing, likes to start fires, prone to chocking when eating.

B. Enter a brief statement acknowledging that an emergency/disaster preparedness plan has been developed by the provider agency and identify where the plan is maintained. For example, "An emergency/disaster preparedness plan has been developed by MDSH, Inc. and is located in the office at Oak Grove Adult Day Services. (Reference DDSN Policy 100-25-DD). For consumers who live with family members who will accept the responsibility for emergency planning, notation of such is required. For example, "John lives with his parents who will make all needed arrangements in case of an emergency or disaster."

SECTION 4: Day Service Summary:

A. The name of the assessment tool used, and the date of when the assessment was conducted.

B. A summary of the assessment results.

NOTE 1: The summary should include prioritized information regarding:

- What the consumer does well;
- Essential needs of the consumer which supports the need for day services & will correspond to proposed interventions for the upcoming year; and
- When applicable, identify strong consumer preferences (ex. prefers not to work on Wednesdays; retirement, wants to be employed full-time, etc.).

NOTE 2: If this has not already been addressed under the "critical information" section, the summary should include information regarding levels of accountability (Reference DDSN Policy 510-01-DD).

NOTE 3: The summary should include the consumer's primary means of communication (ex: words, gestures; sign language; writing; interpreter (explain); adaptive device (identify type), etc.).

NOTE 4: Comment on the consumer's general behavior and when applicable, the effectiveness of any interventions to address the behavior (ex. Behavior Support Plans).

C. If this is not a new consumer, a summary of the consumer's progress on all skills training objectives, and the effectiveness of care and supervision interventions implemented throughout the previous year.

NOTE 1: The progress summary may be written in general terms as long as progress can be defined in the day record (ex. "Progress has been made on Bob's money management objective"); OR written in measurable terms (ex. "Progress has been made on Bob's money management objective. He began the objective 10/03, and relied totally on staff to budget his monthly income. As of 5/04, he now budgets his own monthly income at 90% independence).
Also, report on overall progress. Start with when the training began until the last date the service monitored. Do not just report on the last quarter, etc.

NOTE 2: Include how care and supervision interventions (e.g., medication administration, accountability levels, etc.) impacted the consumer's health. For example, "Over the past year, Bob's accountability levels were effective in

maintaining optimal health and safety. He experienced no accidents/incidents resulting in injury or harm. Bob's medication continues to be administered by staff to insure compliance with physician orders".

D. A list of all of the needs to be addressed by day staff in the upcoming year and the recommended actions to be taken to address each need identified.

NOTE 1: Each need identified in this section should be based on specific needs identified within Section 4 of the Day Service Summary (Item B).

NOTE 2: Each need and action should be written in a person-centered manner, and not service-oriented. For example, "Bob needs day habilitation" is not an appropriate need. The appropriate need could be stated as, "Bob needs to improve money management skills." The subsequent action to address the need could be stated as, "Skills training" or "Skills training to complete a deposit slip".

NOTE 3: There should be a logical relationship among goals and objectives from year to year unless otherwise documented in the record. Objectives should not be fragmented or unrelated from year to year. For example, Bob's current need is to "improve money management skills". He is working on a "budget monthly income" objective. If the need to "improve money management skills" is not recommended within the in the pre-staffing report for the upcoming year, a reason should be document in Bob's day record to explain why.

NOTE 4: The needs identified should justify the consumer's request for day services. Actions should meet the intent of the service definition, for example:

- Day habilitation (e.g., "Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills").

- Prevocational services: (e.g., "Assistance with acquisition, retention, or improvement in preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Activities included in this service are not directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives").

- Rehabilitation Supports: (e.g., "To develop, retain, restore, or improve an optimal level of functioning for consumers in one or more of the following areas: Self-care (ex. dressing, eating, toileting, hygiene, grooming); Community living skills (ex. shopping for goods or services, financial management, safety, transportation; recreation); Personal or social behavior (ex. skills to support a positive impact on self or others; self-determination skills); and/or Medication management and symptom reduction (ex. self-administration of medication or treatment, understanding a health condition). The goal therefore is to enhance the consumer's capacity for successful community living").

NOTE 5: Each action should be assigned a projected completion date. The date is based on when the objective is likely to be completed based the consumer's rate of learning. The date is used as a trigger to evaluate whether or not the consumer's progress is sufficient or if a revision to the objective is warranted.

NOTE 6: Each action should identify a Person Responsible. The person, by name or by title, who will be responsible for implementing the actions noted to address the needs. If a title is used, the title must be specific enough to determine who is responsible. Titles such as Day Coordinator or Day Director are appropriate. Titles such as DSN Board staff, day program staff, etc. are not acceptable.

SECTION 5: Health Information:

A. Identify the name, address and telephone number of the consumer's primary care physician

B. Identify the name, address and telephone number of the hospital the consumer chooses to use.

C. When applicable, identify who administers medications and/or treatments to the consumer while at the day site, (e.g., the consumer; the consumer with assistance from day staff (certified med technician); or licensed nurse).

D. The type of diet the consumer has received, along with any special instructions (ex. 1600 calorie diet, chopped meats w/ no added salt, or regular diet, etc.).

E. When applicable, identify all assistive technology devices or supplies currently prescribed (ex. eyeglasses, wheelchair, etc.); and the specific schedule for use (ex. only when reading, only for transporting, etc).

SECTION 6: Provider Agency Information

A. Identify the Day Provider Agency (to include name, address, and telephone number w/ areas code).

B. Identify the person completing this report (to include: name, title and telephone number w/area code).

SECTION 7: Six Month Review Summary *[Only required for Rehabilitation Support Services]*

The six-month review must be completed/ signed and dated by the Lead Clinical Staff, and add must address the following issues:

- Are current goals and objectives appropriate and effective in meeting the needs and goals of the consumer?
- Are there any other issues pertinent to the functioning of the consumer?
- Do the needs of the consumer support the continuation of rehabilitation support services?

SOUTH CAROLINA Department OF Disabilities AND Special Needs

DAY SERVICES

Report for Single Plan Development ☐ _____ *(date developed)*

Service & Treatment Plan ☐ _____ *(date developed)*

SECTION 1: General Information

A. Day Service Type:

Day Habilitation	☐	
Prevocational	☐	
Rehabilitation Supports	☐	
Other	☐	Specify: _____

B. Funding Source:

MR/RD Waiver	☐	
Medicaid State Plan	☐	
Rehabilitation Supports	☐	
Other	☐	Specify: _____

SECTION 2: Identifying Information

A. Consumer's Full Name: _____

B. Date of Birth: _____

C. Home Telephone Number & Address: _____

D. Primary Contact: _____

SECTION 3: Critical & Emergency Information

A. Critical Information: _____

B. Emergency Disaster Preparedness Plan Information: _____

SECTION 4: Day Service Summary

A. Assessment tool information: _____

B. Assessment results summary: _____

C. Summary of progress and/or regression: _____

D. Proposed Needs & Actions: _____

SECTION 5: Health Information

A. Primary Care Physician _____

B. Hospital of choice _____

C. Medication administration:

- ☐ Consumer
- ☐ Consumer w/ assistance from Direct Support Staff
- ☐ Certified Medication Technician
- ☐ Licensed Nurse

Comments: _____

D. Diet:

Regular	☐	
Restricted Calories	☐	Explain: _____
Restricted Foods	☐	Explain: _____
Pureed	☐	
Chopped	☐	

Comments: _____

E. Adaptive Equipment:

Assistive Technology Device or Supplies	Schedule for Use
_____	_____

SECTION 6: Provider Agency Information

A. Provider Agency: _____

B. Person Completing Report: _____

SECTION 7: Six Month Review Summary

A. [Only required for Rehabilitation Support Services]

- Are current goals and objectives appropriate and effective in meeting the needs and goals of the consumer?

  ☐ Yes ☐ No, explain: _____

- Are there any other issues pertinent to the functioning of the consumer?

  ☐ Yes, explain: _____ ☐ No

- Do the needs of the consumer support the continuation of rehabilitation support services?

  ☐ Yes ☐ No, explain: _____

SECTION 8: Signatures

_____ _____

Consumer/Legal Guardian Date

_____ _____

Lead Clinical Staff Date

FACILITY-BASED
AMENDMENTS TO THE TREATMENT PLAN

DATE:

Check the appropriate reason for amendment:

☐ The consumer has met a goal/objective

☐ The consumer is not progressing toward the goal/objective

☐ The consumer has requested a change

☐ A new goal/objective is recommended

☐ Other: _____

EXPLANATION AND RECOMMENDATION FOR CHANGE:

SIGNATURES:

_____

Consumer

_____

Lead Clinical Staff

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
FACILITY-BASED REHABILITATION SUPPORT
PROGRESS SUMMARY NOTE

Please Type or Print

Consumer's Name: _____ Month/year:

_____

Objective: _____

☐ Accomplished ☐ Making Progress ☐ No Progress

Objective: _____

☐ Accomplished ☐ Making Progress ☐ No Progress

Objective: _____

☐ Accomplished ☐ Making Progress ☐ No Progress

Objective: _____

☐ Accomplished ☐ Making Progress ☐ No Progress

- Activities: ☐ Continue Plan w/o Revision ☐ Revise Plan ☐ Referral
- Health Status ☐ Optimal / Satisfactory ☐ Fair / Poor
- Status of Community Living Skills ☐ Optimal / Satisfactory ☐ Fair / Poor

Comments: _____

Lead Clinical Staff (or designee)	Date

RS Form 4A (8/04)

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

Rehabilitation Supports

NOTICE OF TERMINATION

Please Type or Print

(Must be completed within two days of termination)

Consumer's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Medicaid #: __ __ __ __ __ __ __ __ __ __

The consumer is no longer eligible to receive Rehabilitation Supports for the reason below:

- ☐ Death
- ☐ Voluntary withdrawal
- ☐ No longer needs Rehabilitation Supports
- ☐ Has not received a service for two (2) consecutive calendar months (RS/I only)
- ☐ No longer Meets Eligibility Requirements (Specify):

_____

EFFECTIVE DATE OF TERMINATION: _____ / _____ / _____
(must be completed)

As a result of this termination, the services and activities, which are currently provided and funded through Rehabilitation Supports, will no longer be funded in this manner.

☐ Individual Rehabilitation Supports ☐ Facility Based Rehabilitation Supports

Please Type or Print

Rehabilitation Supports Lead Clinical Staff Name: _____

Provider:

_____

Address: _____

Phone: ( ) _____

Signature: _____ Date: _____
Lead Clinical Staff

Original: ☐ Recipient/Family Copy: ☐ Service Coordinator / Early Interventionist & Consumer's Record Copy: ☐ DDSN Finance Division

RS Form 6

(1 of 2)

PROCESS FOR APPEALING DECISIONS

If you are being terminated from Rehabilitation Supports, you have the right to appeal. Appeals must be made within 30 days of notification of a decision with which you disagree.

Since SC Department of Disabilities and Special Needs (SCDDSN), through the county Disabilities and Special Needs (DSN) Boards, is responsible for the day to day operations and decision making regarding Rehabilitation Supports, it is recommended that, at first, disagreements be sent in writing to the Executive Director of the county DSN Board in your home county.

In this county, the Executive Director is _____ and he/she can be reached at this address:

_____

_____

_____

If you are still not satisfied, it is suggested that you appeal to the State Director of SCDDSN. The State Director is Stanley J. Butkus, Ph.D. and he can be reached at P.O. Box 4706, Columbia, SC 29240

It is hoped these suggested steps would resolve your dissatisfaction.

A Medicaid applicant/recipient has the right at any time to request a fair hearing from the SC Department of Health and Human Services regarding a decision affecting Medicaid eligibility or services. To initiate the appeal process, you or your representative must submit a written request to the following address no later than thirty (30) calendar days from the receipt of written notification for any action adversely affecting your Medicaid coverage.

Division of Appeals and Hearings
Department of Health and Human Services
Post Office Box 8206

Columbia, SC 29202-8206

Please attach a copy of the written notification with your appeal request. In your request for a fair hearing, you must state with specificity the issue(s) you wish to appeal.

Unless a request is made within thirty (30) calendar days of receipt of written notification, the decision will be final and binding. A request for a fair hearing is considered filed if postmarked by the thirtieth (30th) calendar day following receipt of written notification. You will be advised in writing by the Division of Appeals and Hearings as to the status of your appeal.